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CLINICAL ADVISORY

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To: Emergency and Ambulatory Care Departments
Departments of Medicine
Departments of Infectious Diseases
Departments of Gastroenterology
HIV/AIDS Health Care Providers

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RE: Clinical Advisory: Lymphogranuloma venereum (LGV) presenting as inflammatory bowel disease or proctitis

A recent Morbidity and Mortality Weekly Report (MMWR-October 29, 2004/53(42):985-988) of the Centers for Disease Control and Prevention (CDC) alerted clinicians to an increase in the number of cases of LGV among men who have sex with men (MSM) in the Netherlands. Typically, fewer than 5 cases a year are reported in that country. As of September 2004, a total of 62 cases had occurred. **Except for one, all patients had gastrointestinal symptoms** (e.g. bloody proctitis with purulent or mucous anal discharge, tenesmus and constipation). Some patients in this LGV outbreak had reported multiple sex partners in cities in Europe and the United States.

LGV is caused by *Chlamydia trachomatis* (CT) serotypes L1, L2 and L3. LGV is a rare disease in the United States. To date, 2 confirmed cases of rectal LGV have been reported in the United States in MSM who presented with similar symptoms as the cases in the Netherlands. Other suspected cases are being investigated.

Although no case of rectal LGV has been reported to-date in Massachusetts, clinicians should be aware of this clinical presentation of LGV. **CDC advises clinicians who care for MSM to consider LGV in the diagnosis of compatible syndromes (e.g. proctitis and proctocolitis) and perform tests to diagnose *C. trachomatis* infections without regard to the specific LGV serovars.**

Diagnosis of LGV

The diagnosis is based on clinical findings, supported by serologic tests for CT (complement fixation test with a titer of $\geq$ 1:64 or a microimmuno-fluorescence test with a titer of >1:128) or direct identification of CT by culture or nonculture nucleic acid testing. Serologic testing, which has not been well standardized, is not considered specific for LGV, but can support a clinical diagnosis. Direct identification by commercially available methods is also not specific for LGV serovars of CT. Use of rectal swabs for nucleic acid testing has not been cleared by the U.S. Food and Drug Administration, but has been validated by some health department laboratories. The CDC is collaborating with health departments to assist in the laboratory diagnosis of LGV with specialized amplified nucleic acid testing.

Treatment of LGV

The recommended treatment for LGV is doxycycline 100 mg orally, twice a day, for 21 days. Alternative treatment is 500 mg of erythromycin base orally, four times a day, for 21 days. Some experts believe that azithromycin 1 gram orally, once weekly, for 3 weeks, is effective (however, clinical data are lacking).

Sex partners who had contact with the patient within 30 days of the patients' onset of symptoms should be evaluated. In the absence of symptoms, they should be treated with either 1 gram of azithromycin in a single oral dose or 100 mg of doxycycline orally, twice a day, for 7 days.

Recommended Approach

- Clinicians who care for MSM should consider LGV in the diagnosis of compatible syndromes, particularly proctitis. Other manifestations of LGV include tender lymph nodes (inguinal and/or femoral which can become fluctuant) and anogenital ulcers (small, generally painless ulcer followed by the appearance of tender lymph nodes)
- **Contact the Division of STD Prevention if you suspect a case of LGV**. **We can assist in direct identification and serologic testing for CT in cases compatible with LGV as well as with partner management services**
- Perform direct identification testing for CT per STD Division recommendations
- Perform testing for *Neisseria gonorrhoeae* and other STDs (syphilis; HIV and HSV as appropriate).
- Perform serologic testing for CT
- Cases compatible with LGV should be treated presumptively or until all tests used to support the diagnosis are negative for CT/LGV

For more information on specimen collection/testing and other assistance, contact Sylvie Ratelle, MD, MPH or Bill Dumas, RN, Division of STD Prevention, at (617) 983-6940.